Smoky Mountain Center (SMC)
Operations at a Glance – August 2012

SMC is committed to being a transparent organization and keeping stakeholders informed. To support these efforts, SMC will create a brief, monthly summary of operations by functional area.

Individuals Eligible for Medicaid Services through SMC

SMC is responsible for the oversight of behavioral health and intellectual/developmental disability Medicaid services in our 15-county area. For August:

- Individuals on the NC Innovations waiver: **640**
- Other individuals who receive Medicaid: **74,751**

Explanation: Each month the North Carolina Division of Medical Assistance (DMA) pays SMC a capitated amount per Medicaid recipient (numbers above). From those funds, we must manage services for any individual in SMC's 15 counties who needs a Medicaid service for mental health, intellectual/developmental disabilities, or substance abuse.

Customer Services (Medicaid and State-funded)

- SMC customer service representatives answered: **3,406 calls during August and 8,184 YTD**
- Average time to answer a call: **14 seconds during August and 15.75 YTD**

Explanation: Customer service representatives take calls related to accessing services, answering questions, and providing support. SMC is required to answer calls within 30 seconds.

Care Management/Utilization Management (Medicaid Only)

- SMC care managers processed **2,896** requests for the authorization of services **during August and 6,237 YTD**.
  - Average time for review and authorization of requests: **3.4 days during August and 3.6 YTD.**
  - Mental health or substance abuse service requests: **2,224during August and 2,250 YTD.**
  - Intellectual/developmental disability service requests: **672 during August and 1,987YTD.**
  - Requests not authorized: **557 during August and 1,054 YTD.**
    - Incomplete or inappropriate requests: **552 during August and 1,048 YTD.**
    - Requests without supporting evidence for "medical necessity": **5 during August and 6 YTD.**
- Reconsideration requests: **1 during August and 1 YTD.**
- Reconsideration decisions appealed**: 0 during August and 0 YTD.**

Explanation: Many Medicaid services require prior authorization. In this process, a care manager reviews a request for services along with supporting documentation for "medical necessity." Services that meet "medical necessity" criteria are necessary and appropriate for prevention, diagnosis or treatment, and reasonably related to the diagnosis for which prescribed. SMC expects care managers to complete service request reviews within 14 days of receipt.

When SMC denies a request for service due to lack of medical necessity ("adverse decision"), the consumer has the right to appeal the decision. In an LME-MCO, the consumer must exhaust the local reconsideration process before filing an appeal for a State Fair Hearing. During a local reconsideration, SMC staff, the consumer, and other people the consumer invites discuss the service request in relation to the consumer's condition. The group tries to agree about treatment that is medically necessary and meets the consumer's needs. A successful reconsideration is one that does not result in the consumer requesting a State Fair Hearing.

Care Coordination (Medicaid and State-funded)

- SMC Innovations care coordinators worked with **648** individuals/families during August.
- SMC has **373** individuals on the waiting list for a NC Innovations waiver slot at the end of August.
- SMC mental health or substance abuse care coordinators worked with **616** individuals/families identified with special healthcare needs or who are at high risk during August.

Explanation: The Medicaid 1915 (b)/(c) Waiver clearly defines criteria for people considered to have special health care needs. The LME-MCO must ensure that care coordination occurs for those individuals. Individuals who have high-risk conditions or those who use an amount of services considered high-cost (the top 20% of service dollars) also receive care coordination. The goal is to ensure that all individuals receiving care coordination have access to the right amount of clinically appropriate care.

Quality Management (Medicaid only)

- SMC staff handled **12** grievances **during August and 28 YTD**.
  - Grievances about SMC: **4 during August and 8 YTD.**
  - Grievances about providers: **8 during August and 20 YTD.**
- Of the 12 grievances received in August, **11** are fully resolved.
- Average time to resolve a grievance: **11.58 days during August and 12.31 YTD.**

Explanation: SMC is required to track all grievances. The definition of grievance is "an expression of dissatisfaction by or on behalf of an Enrollee." A grievance is about any matter other than a service request that does not get prior authorization. SMC is required to resolve grievances within 30 days of their receipt.

Finance/Claims (Medicaid only)

- SMC Claims Specialists processed **59,317** claims **during August and 78,025 YTD**.
  - Claims approved and paid: **47,042 during August and 61,841 YTD**
  - Average time to process a "clean claim": **2.7 days during August and 2.6 days YTD**
  - Claim payments: **126** providers received **$3,657,770.36 during August and $4,305,342.01paid YTD.**

Explanation: SMC now processes Medicaid claims. SMC is required to process a claim within 18 days of receipt, and is required to pay 90% of clean claims within 30 days. A "clean claim" is one that can be processed without obtaining additional information from the provider. SMC uses the AlphaMCS software system. The software is programmed to ensure that all claims SMC receives through AlphaMCS are "clean claims." SMC pays providers on a weekly basis. This means that once a claim is processed and approved, the provider rarely has to wait longer than 8 days to receive payment.

Provider Network (Medicaid and State-funded)

- There are **236** providers in SMC's network as of the end of August.
- As of the end of August, SMC has agreements with **four (4)** providers outside our network who provide services to individuals with Medicaid eligibility in one of SMC's 15 counties.

Explanation: Before "going live" on the Waiver, there were 162 providers in the SMC network. During Waiver implementation, SMC offered contracts to 263 providers. SMC now operates a closed provider network. That means SMC must determine a need or gap to introduce a new service to the network. When that happens, SMC may contract with a new provider, or request that a current network provider add the service to its array.